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Challenges in 'Translating' Human Rights: Perceptions and Practices of Civil Society Actors in Western India

Maya Unnithan and Carolyn Heitmeyer

ABSTRACT

Rights-based approaches have become prevalent in development rhetoric and programmes in countries such as India, yet little is known about their impact on development practice on the ground. There is limited understanding of how rights work is carried out in India, a country that has a long history of indigenous rights discourse and a strong tradition of civil society activism on rights issues. In this article, we examine the multiple ways in which members of civil society organizations (CSOs) working on rights issues in the state of Rajasthan understand and operationalize rights in their development programmes. As a result of diverse 'translations' of rights, local development actors are required to bridge the gaps between the rhetoric of policy and the reality of access to healthcare on the ground. This article illustrates that drawing on community-near traditions of activism and mobilization, such 'translation work' is most effective when it responds to local exigencies and needs in ways that the universal language of human rights and state development discourse leave unmet and unacknowledged. In the process, civil society actors use rights-based development frameworks instrumentally as well as normatively to deepen community awareness and participation on the one hand, and to fix the state in its role as duty bearer of health rights, on the other hand. In their engagement with rights, CSO members work to reinforce but also challenge neoliberal modes of health governance.

INTRODUCTION

National governments worldwide have adopted a universal, legal language of rights. However, there is as yet limited understanding of how rights work

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is carried out in countries like India that have a long history of indigenous rights discourse and a strong tradition of civil society activism on rights issues.[1] In the more recent domain of rights-based development,[2] numerous international and Indian civil society organizations (CSOs)[3] are now working with the state to promote the right to healthcare, especially for poorer women. But how do they bring together the different approaches to rights and how do they use, shape and translate global ideas of rights in their programmes? In what ways does the very use of a universal human rights framework usher in new forms of politics and change development practices and institutions? This article aims to scrutinize and understand the implications of human rights discourse 'on the ground' through the perceptions and practices of local development actors. We focus on the rights work of CSOs in the state of Rajasthan, northwest India, to show how 'rights talk' is selectively translated into particular concrete actions — actions which reconcile the state rhetoric of empowerment and its programmes for enhancing participation, the development goals of activists, and their understanding of their own role as moral agents.

Merry (2006) argues that for human rights to be effective, they have to be translated into local terms and situated within local contexts. Drawing on Merry's approach to the translation of human rights as a process that requires both appropriation and transformation, we argue that there is no 'single' understanding of human rights but rather multiple and contested translations which are selectively appropriated by CSO workers. With reference to the right to health in particular, we propose that such 'translations' reframe the terms of engagement between civil society, local communities and the state. Focusing on the ways in which a rights-based framework is understood, interrogated and strategically deployed by indigenous rights actors in local, community and regional rights-based organizations (*sangathan*), we bring to the fore the creative and participatory processes that have resulted from CSO rights work in India. We show how an engagement with rights has

1. Exemplified by the struggle for independence from British colonial rule in the nineteenth century, as encapsulated in Gandhi's notion of *swarajya* or self-rule, but also in the language of everyday claims spoken in the household and family, such as *haq, adhikar, nyay* (Madhok, 2009; see Unnithan-Kumar, 2003, for local articulations of reproductive rights).
2. Human rights ideas started to inform development thinking as late as the 1980s. It was the 1986 UN Declaration on the Right to Development that obliged member states to create a just and equitable environment with a view to realizing the right to development (Cornwall and Nyamu-Musembi, 2004).
3. After careful consideration of different terms (CSO/NGO/voluntary organization), we have decided to use the term 'CSO' for the sake of clarity and uniformity. There is significant overlap between these terms, but given that the argument does not hinge on questions of whether and how CSOs differ from NGOs (generally they are the same but the term NGO has taken on a pejorative connotation over the last decade), we have decided to keep things simple. We thus use the term CSO, which is also a preferred term of self-identification of the organizations studied, to refer to the work of primarily charitable, autonomous and not-for-profit organizations.

required ('disciplined') such organizations to employ particular modalities (of rights advocacy, for example) and not others (to do with service delivery), thus becoming 'complicit' in processes that undercut their own position (in inequitable state–civil society partnerships); see Unnithan and Heitmeyer (2012). As moral agents, CSO workers constantly negotiate between their perceived responsibility towards the community, their responsibility towards their organization and their own understandings and aspirations for justice. Such mediation, we argue, is reflected in rights-based CSOs working with the state to implement rights-based health initiatives while simultaneously mobilizing local communities to make health-based claims on the state.

The transformatory potential of human rights discourse in development has been subject to sustained critique by social theorists (notably Brown, 2004; Žižek, 2005), anthropologists (such as Cowan, 2006; Englund, 2006; Wilson, 2001;Wilson and Mitchell, 2003) and Indian scholar-activists (e.g., Batliwala, 2007; Qadeer and Vishwanathan, 2004; Rao, 2004). These authors emphasize the North–South inequalities inherent to a human rights discourse that 'legitimates the intervention of western powers politically, economically, culturally and militarily in the Third World countries of their choice' (Žižek, 2005: 128). Of particular significance is how, within these countries, human rights frameworks constitute forms of subjectivity which reinforce rather than challenge the existing status quo, and support neoliberal paradigms of development (Brown, 2004). Others see rights-based approaches, though problematic, as an opportunity for development actors to re-politicize and salvage notions of participation and empowerment from neoliberal instrumentalism (Cornwall and Nyamu-Musembi, 2004). In terms of a popular engagement with human rights discourse in the South, some anthropological work, especially in the context of South Africa, has shown that human rights ideas function to further disempower the poor and politically marginalized (Wilson, 2001).[4] Other anthropologists mapping AIDS activism in these regions are beginning to suggest more selective and nuanced appropriations of rights talk (Macgregor and Mills, 2011). Recent civil society engagement with human rights in India, as indeed in South Africa, is historically informed by processes where rights have resulted from struggle, making for a very distinctive political orientation of civil society to rights frameworks and to the state as guarantor of such rights. However, civil society activism to do with the right to information (1994–2005) in Rajasthan shows that rights work (also on health) is most effective when it is connected with economic, and not only political transformation (Jenkins and Goetz, 1999; Roy, 2010).

Civil society, however, is heterogeneous and CSOs also a focus of criticism, both in India and elsewhere (Arvindson, 2008; Ferguson, 1994; Gellner, 2010; Henkel and Stirrat, 2001; Lewis, 2002; Mosse and Lewis,

4. A similar argument is made by Englund (2006) in his study of activists in Malawi.

2006). Due to widespread disillusionment with state-led development, rising privatization and neoliberal market reforms, the rapid proliferation of CSOs in countries of the South in the 1980s and 1990s was welcomed (Gardner and Lewis, 1996).[5] The variable quality of their development work and questionable local accountability has, however, made them unpredictable as agents of bottom-up development. In this context, the human rights-based approach of the late 1990s was regarded as a panacea, a measure that would remedy all ills of the CSO sector, such as the lack of downward accountability (Kilby, 2006). It stimulated CSOs to reflect on and address their own hierarchies and self-interested relations with national and international organizations. Such self-reflection on internal practices was far-reaching enough to lead to the remaking, or the implosion, of some organizations.

This article examines a more recent and critical role of CSOs as mediator at the juncture where human rights meet large-scale public health sector reform in India. It focuses on how CSO workers in Rajasthan understand rights, how they apply their ideas in their everyday institutional context, and how they have developed context-based translations of rights and forms of accountability. The article therefore explores 'rights work', as well as how and to what end rights 'work' in development. The approach is ethnographic in the sense that it draws on the emic understandings (meaning attributed) of a range of actors located within a specific CSO and its networks at the local, regional, national and international levels. The fieldwork for this article was conducted in Rajasthan from July 2009 until June 2010, as part of a wider project on understanding the role of rights-based organizations in promoting reproductive health in India. Thirty-four civil society organizations were selected to reflect the wide range of CSOs that explicitly or implicitly regard their work as rights-based. Included was a diverse array of groups ranging from those concerned with broad, rural social transformation, to smaller issue-related organizations working in clusters (in the areas of livelihoods, food, education, health), to more specifically health service-oriented and clinically focused organizations. Also included were charitable and activist organizations, namely, broader feminist and gender-focused collectives; struggle- and movement-based groups; newly developed corporate-linked organizations; state-initiated, national organizations with local bases in Rajasthan; and international organizations with (and without) a strong local basis.[6] In this article, we focus primarily on

5. A recent sample survey of the size of the non-profit sector in India, for example, has placed the number of such organizations at 1.2 million (Srivastava and Tandon, 2005).
6. In conducting the research, we drew largely on qualitative methods and multi-sited ethnography (Marcus, 2008) to gain insight into the understanding of state and non-state actors of rights, activism, health, and organizational processes. A total of 133 detailed questionnaires were collected in which participants were asked to reflect on a wide range of topics; from their understanding of human rights and the most pressing health issues in Rajasthan to personal perspectives on institutional processes and career choices. These questionnaires

Endeavour (a pseudonym), a large nodal CSO which draws together a group of fourteen CSOs. The focus on Endeavour enables us to examine civil society rights work at different levels; in the community, in several networks with other CSOs, with international organizations and with the central state.

Exploring rights-based development from the perspective of CSO workers provides insight into the way boundaries operate 'within' institutions (Mosse, 2004), and the kinds of networks they facilitate with other organizations, including state agencies. In this context, 'rights' emerge as bounded and clearly defined tools for some, while others view 'rights' at a more discursive level, as something through which social change is enacted. The article is structured as follows. First, we situate state and civil society mobilization around the right to health within broader, more recent historical trends of rights-based mobilization in Rajasthan. Next, we give an account of the ways in which CSO workers talk about rights, so as to capture a sense of the contested meaning of rights in general and specifically in relation to health entitlements. Following this, we examine the multiple forms of rights work undertaken by Endeavour and finally discuss the implications of their rights-based work for development practice and outcomes.

The observations made in this article are historically and culturally restricted to one part of India, the western state of Rajasthan, and to one set of development concerns related to gender and health. Home to approximately 56 million people, Rajasthan is of particular interest for two main reasons. Firstly, Rajasthan is categorized as a 'backward state' due to its poor maternal and infant health and literacy rates (Government of India, 2009a). Secondly, it has been the focus of intense gender and health development interventions by national and state governments, as well as international UN organizations for over thirty years (UNICEF and UNFPA, in particular). It is also a state that has witnessed pioneering forms of social activism in the field of development, of which the Women's Development Programme of 1984 is a noteworthy example (Kabeer, 2005; Mathur, 2004; Unnithan and Srivastava, 1997). In the 1990s the state witnessed large-scale popular mobilization around the Right to Information which resulted in the Right to Information Act in 2005, which is briefly discussed below.

The privatization of healthcare accompanied by public–private partnerships is a contentious issue that has generated much civil society activism, both in Rajasthan and nationally (for example, through the Jan Swasthya Abhiyan or People's Health Movement).[7] Most CSOs we worked with advocated state provision of healthcare as a means to halt the

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were complemented by a series of focus group discussions conducted among CSO workers and a review of documentation produced by both state and non-state groups.

7. The Jan Swasthya Abhiyan (JSA) is the Indian chapter of the People's Health Movement, a global network of health activists that was established in 2000 to hold governments accountable to the 1978 Alma Ata Declaration on universal healthcare, to be achieved by 2000.

marketization of health services (Unnithan and Heitmeyer, 2012). At the same time, criticism of state intervention voiced by nodal CSOs served to diffuse the state's monopoly over rights discourse and challenge the corporate (including pharmaceutical) appropriation of rights terminology. As Nichter (1996) has observed, the latter is used to promote health consumerism and commodification, which contradictorily has a disempowering effect on the poor and growing lower middle class. The following sections discuss the implications for rights work of CSO actors caught between the two opposing roles of promoting and opposing state development initiatives.

CONTEXTS: THE LANDSCAPE OF RIGHTS AND 'TRANSLATION'

The application of human rights ideas and language in the planning and implementation of development programmes — referred to as 'rights-based approaches to development' in this article — is illustrative of a more recent 'turn' to rights in state development discourse and practice (Joshi, 2009; Petitt and Wheeler, 2005), and the location of gender within governance discourse (Gopal Jayal, 2003). This is in contrast to 'rights work', which refers to the longer history of civil society activism aimed at social transformation among poorer and vulnerable groups.[8] The terms 'empowerment' and 'participation' embody this orientation among activist groups in the 1980s (Cornwall and Welbourn, 2002; Eyben, 2009). In India, the turn to rights in state development discourse in the 2000s marked a departure from a separate needs-based approach (with an emphasis on rights as a basis for affirming and realizing economic demands) and viewing them as inseparable from social, civil and political rights (Nussbaum, 2000; UNRISD, 2000). Above all, rights-based approaches underscore the need for a reflexive engagement with power, holding both state and non-state actors to account.

CSO activism focusing specifically on health is a relatively recent phenomenon in India. Yet, feminist mobilization against the family planning atrocities of the 1970s and around safe motherhood in the 1990s was an important precedent (Chayanika et al., 1999; Indian Women's Collective, 1989; Qadeer and Vishwanathan, 2004; Ramasubban and Jejheebhoy, 2000; Rao, 2004; Unnithan-Kumar, 2003). The right to health is the foundation of the current National Bill on Health (2009, not yet an Act of Parliament) and of programmes within the 2005 National Rural Health Mission. As in countries such as South Africa and Brazil, for example, health-oriented rights groups have set out to challenge the inevitability of maternal mortality

8. In Rajasthan, this is reflected in the work of organizations such as the Social Work and Research Centre in Tilonia, the Mazdoor Kisan Sangh in Tilonia (Roy, 2010) or Sewa Mandir in Udaipur, for example.

(Das, 2010) and the inaccessibility and cost of medication for poorer groups (Biehl, 2007; Das, 2010). While some research has been conducted on the institutional and community-level impact of using rights-based approaches to health (Cornwall and Shankland, 2008), little is understood about how CSOs in India have engaged with and mobilized around the new explicitly rights-based paradigm (Batliwala, 2007),

The role of CSOs in promoting health rights has emerged at two important junctures in the recent history of development in India. In 2005 the National Rural Health Mission (NRHM) initiative ushered in the implementation of major and sweeping health sector reforms.[9] In 2009 the draft National Health Bill was presented. The NRHM is a prime example of state–CSO partnerships formed in the context of the right to health. Civil society organizations were recruited to oversee the local-level participatory aspects of the programme, notably village-centred health planning and the monitoring of state allocated funds (through the Village Health and Sanitation Committee or VHSC, a specific body set up for the purpose). The draft National Health Bill of 2009, on the other hand, sought to legislate the 'right to health' in India. It was developed in partnership between civil society groups (notably organizations of the Jan Swasthya Abhiyan, the Indian branch of the global People's Health Movement) and government policy makers. As the official Ministry of Health website states, the framework [of the law] would comprise the following: 'people's rights relating to health and health care; concomitant obligations of governments as well as private actors; core principles on health rights and obligations; institutional structure for implementation and monitoring; and justice mechanism [sic] for health rights' (Government of India, 2009b).

The intended legislation follows a longer-standing trajectory of rights mobilization and legal enactments initiated by civil society and the Rajasthan branch of national organizations, such as the Peoples Union for Civil Liberties, PUCL and the Jan Swasthya Abhiyan (JSA). It involves the right to information (Right to Information Act, 2005), followed by the right to employment, synonymous with the Mahatma Gandhi National Rural Employment Guarantee Scheme Act (MGNREGS Act, 2006) and the current protracted process involving the Right to Food movement that pertains to the right to a minimum standard of nutrition (the Food Security Bill is yet to be passed by parliament).

Rights-based legislation is significant for people on the ground because it has proven to be effective in securing essential commodities for survival.

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9. The NRHM programme was launched in 2005 in eighteen Indian states, Rajasthan being one of these, which were seen to have weak public health indicators and/or a weak infrastructure (Government of India, 2006). A seven-year programme, its specific remit was to 'undertake architectural correction of the health system to improve access to rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare' (Das and Bhatia, 2007: 5).

The success of the Right to Information (RTI) activists can be attributed to the creative connection they made between people's right to information (about government development funds allocated for their wages) and the constitutional provision guaranteeing the right to life and livelihood (Jenkins and Goetz, 1999). It is this ability to creatively 'translate' local concerns into a rights framework and combine one set of rights, civil and political, with another set of basic economic and social rights that we seek to explore further in the context of health-focused legislation and programmes.

Merry (2006) has termed the processes of translation adopted by development activists as one of 'vernacularization', where the structure and rhetoric of human rights interventions are 'adjusted' to local circumstances and where programmes are appropriated, translated but not fully indigenized, enabling both a 'breaking from the mould as well as a ready adaptation' (ibid.: 135; Goodale and Merry, 2007). Merry's analysis, while useful, stops short of analysing the ways in which human rights translations are contested within the highly diverse CSO community, and the actual processes that determine the diverse kinds of translation that take place (normative or instrumental, for example).

Understanding what global notions of human rights come to mean within local contexts is especially important in India where a distinction has to be drawn between legal rights as outlined in the Indian Constitution; as set out in international human rights treaties; and as they are practised in everyday contexts, as locally framed claims, entitlements and duties. The work of CSOs as 'translators' of human rights ideas and practices is particularly pertinent given the disconnection between the global human rights language and everyday social realities of the communities it pertains to. Among most communities, castes and classes in Rajasthan, notions of rights are overlaid by a strong sense of notions of duty (*dharma, farz*), grounded in kinship and relational ties (conjugal, filial, parental and so on). Duties are primarily constructed as the responsibility of members of a community to their family, caste and village councils, rather than in terms of these institutions meeting the rights of their members.

For most women and men from a lower- and middle-class background in Rajasthan, the idea of claiming rights from the state is an alien concept. Like a group of caste elders, the state is regarded as *mai-baap* (a senior kinsperson, literally: mother-father) that acts as parent to its children, fulfilling the role of benevolent caretaker of their rights. A 'natural' responsibility is attributed to the state and to customary social institutions, both of which are presumed to uphold the rights of individual members, making the actual staking of claims by individuals out of place and morally unacceptable. The emphasis on rights has been especially important for feminist activists who have seen the notion 'rights-imply-duties' appropriated by those disinclined to promote women's claims and entitlements, and who emphasize women's familial responsibilities rather than their rights. In fact, the critical input of gender and rights activists in Rajasthan has been to make rural women aware

that 'they need to think about their rights in terms of their own entitlements rather than in meeting the entitlements of others, often glossed as "one's duty"'.[10]

CSO workers, often acting as mediators between local communities, on the one hand, and the state and development networks, on the other, play a central role in reconciling these multiple discourses. The way in which selective aspects of rights are translated also rests with the individual actors who do the translating and who bend, amend and contest human rights ideologies to fit particular agendas, exigencies and funding priorities. In this context, the extent to which local health requirements (infrastructure and services) are met depends on the ability of designated CSOs to capture government resources for local health needs. CSOs cannot be reduced to 'neutral facilitators' of such processes as they have significant leveraging power in their role as intermediaries between the state and local communities in such initiatives. Their locally grounded understanding of rights gives CSO members power over the state and the communities they work with.

TALKING RIGHTS: DIVERGENT PERSPECTIVES ON RIGHTS WITHIN CSOs

The recent history and rapid surge of rights-based activism and legislation in Rajasthan over the past decade has generated significant debate and discussion 'on the ground', among a range of activists from different caste and class backgrounds, about the relation of rights to struggle, duties and the individualizing nature of human rights. These debates and discussions reflect the particular ways in which the rhetoric of human rights is interpreted, conditioned by local contexts and deployed in various development programmes as a tool, a guiding principle, a means of enforcing accountability, to re-frame the terms of engagement ('participation') with the state and to politicize development practice.

Within Rajasthan, 'right' is often translated into local languages (primarily Hindi as well as regional Rajasthani dialects) through use of the terms *haq* and *adhikar*. Deriving from Arabic/Urdu, *haq* was originally used to denote 'something right, true, just, and real'; in later incarnations, it was associated with religious ideas of a permanent law in the context of Islam (Madhok, 2009: 13). Commonly translated as 'rights', *adhikar* was used to designate power or office (that is, the rights or privileges associated with a particular title or rank) in the nineteenth century (ibid.: 16).[11] The CSO workers among

10. Personal communication with I. Pancholi, Mahila Jan Adhikar Manch, Ajmer, March 2009.
11. In her analysis of the terms as used in Rajasthan, Madhok (2009) suggests that despite some overlap between these indigenous notions of rights and the rights of mainstream liberal theory, the former are generally broader in scope in that they incorporate individual *and* collective rights, as well as positive and negative rights.

whom we conducted our research used both *adhikar* and *haq* to describe their work, but *adhikar* was the main term used to denote 'rights'.[12] The English 'human rights' was also used although mainly by middle-class professional workers.

'Rights talk' took place in many different settings and locations, from village-level committees to CSO offices, state coordinating committees and international organizations. Different concerns were raised within the CSO communities, networks and even some individual CSOs about the implications of rights-based approaches for development and policy initiatives. Among individual CSOs, the more senior and elite members engaged in discussions about drafts of national rights-based legislation, such as the National Food Security Bill and the National Health Bill. In the debates on the health bill for example, an important point of contention was whether a rights-based approach implied prioritizing access to healthcare for the most marginalized communities or providing universal access for *all* communities. The national representative for the JSA argued that a bill that targets 'vulnerable and marginalized groups' would ultimately weaken healthcare coverage for the rest of the population. Likewise, the head of the nodal CSO Endeavour, who also represented the state-level branch of the JSA for Rajasthan, suggested that the prioritization of vulnerable and marginalized groups conflicts with the universal nature of human (and health) rights. From a slightly different perspective, the head of one of the leading national human rights advocacy groups argued that the draft bill was so poor as to require a complete rewrite. He voiced strong objection to state efforts to ratify the bill allowing private health providers to play a greater role in strengthening the public health system — a position supported by the majority of CSOs.

Apart from reflecting points of contention regarding the formulation of rights policy, the discussion above reinforces the idea of human rights as an important instrument in the formulation of policy and law offering greater leverage for accountability and empowerment for citizens. The approach to rights as an instrument or tool is generally more typical of activists working at national and international policy level (many of whom, though not all, tend to be conversant in English and from an educated, middle-class background). As we show in the section below, the way in which CSO workers from different castes, classes and positions within the organization assess the value and utility of rights varies greatly, as does their instrumental use of human rights.

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12. For example, human rights was translated as *manav adhikar*, health rights as *swasthya adhikar*, and the right to information as *suchna ka adhikar*.

Rights Talk 'On the Ground'

Unlike national-level CSO representatives working at policy level, CSO workers involved in local campaigning, service delivery and community mobilization activities relate to universal ideas of rights as these ideas apply to their everyday work. Many CSO workers associated rights-based language with wider political and social struggle (*sangharsh*), as a way to demand accountability from the state or justice from local-level power interests. As noted by a female worker (from a middle-class and caste background) at mid-management level in a health rights organization: 'Human rights enable us to work towards achieving human needs like employment (*rozgar*) through struggle (*sangharsh*). [Human rights means] achieving human needs through struggle'.[13] Another widespread notion associated with human rights in grassroots organizations was: '[Human rights mean that] poor, marginalized, women, dalit[14] and helpless people have the right to live comfortably'.[15]

More critical views on rights were expressed by the more established CSOs. As the then-chief executive officer (from an upper-middle-class background) of a major CSO in southern Rajasthan explained:

> We have great discomfort with the term 'rights-based approach' because, as it is currently understood, it implies that people are only beneficiaries rather than also having responsibilities as well . . . . [Our organization works to bring] about change through community involvement whereas the rights-based approach assumes that the poor are always victims even though they should also be seen as participants . . . social problems need to be solved by the family and the community. (Nandini, 12 December 2009)

As Nandini suggests, the focus on individual entitlements is seen as reinforcing the status of victimhood of the poor which, she went on to explain later in the conversation, discourages communities from tackling social problems independently of the state; that is, locally and collectively.

Similarly, another member of a marginal but politically powerful group belonging to a dalit organization criticized the rights discourse for its lack of emphasis on responsibility: '[The weakness with the rights-based approach] is that people are not fulfilling their duties. Everyone talks about rights but not their duties (*rights ki baat sab karte hain par duties ki nahi*)' (Satish, the dalit state coordinator of the CDR organization, 25 March 2010). The discomfort with the rights-based approach, and its alleged emphasis on the entitlements the state owes the individual, rather than the responsibilities of the individual towards other collectives, such as the kinship group or society in general, was a concern shared by many. This included respondents working in the development and CSO sector, as well as key lawyers and statesmen involved in human rights legislation (including the director of the state Human Rights

13. Interview, Chotti Sadri, Rajasthan, December 2009.
14. The term 'dalit' is a name adopted by more politicized members of the Scheduled Castes ('ex-untouchables').
15. Interview Bikaner, Rajasthan, November 2009.

Commission),[16] which shows how deeply entrenched the ideology of duty and paternalism (the notion of *mai-baap*) is.

Scepticism could also be found among CSO workers who remarked that, as one of the dominant paradigms in the development sector, 'human rights' has increasingly become a development buzzword and understood in a way that is disassociated from the original principles of individual dignity. As Seema, a senior and middle-class member of Endeavour, set out:

> It is a great thing that everyone is talking about rights — but at times [people are] just following a trend . . . Most of the time, organizations and people working in them may be working with an incomplete understanding. [I am] worried that it may [not] lead to concrete results (while it is easier to get funds by using rights-based approach, it should not just go with the trend).[17]

In this quote, Seema expresses the concern that in the quest of CSOs for funding, human rights may become indistinguishable from other development jargon (empowerment, participation, etc.). This concern was echoed by Ajit, a leading public health professional turned activist based in Delhi who has played a prominent role working with the state to include rights language in national policies and initiatives such as the NRHM. He drew particular attention to the fact that in the discourse on human rights, the concept is often uncritically accepted and assumed to entail positive outcomes for all stakeholders. Another equally problematic perception he noted was that 'consultation with stakeholders' automatically characterizes an initiative as 'rights-based', irrespective of the quality of engagement. He notes: 'The assumption . . . is that the rights-based development is going to be good for everyone and that everybody will have the same perspective. Rights-based development incorporates different perspectives . . . the assumption is that if we talk to all the stakeholders that will automatically make it "rights-based"'.[18] In contrast to Ajit's concern about the implications of a rights-based approach for institutional practices, Sita, the well-educated director of UNICEF programmes, highlighted the importance of a rights-based approach among her own staff: 'Rights work as a spotlight and as a searchlight to highlight violations. As such, working with a rights-based approach means that processes become just as important as results'.[19]

Understandings of a rights-based approach to health were focused mainly in two areas: health services and health advocacy. With regard to the former, the concern was largely with the extent to which rights were conflated with (or disconnected from) quality, safety and accountability in health service delivery. At the time of conducting this research, in 2009, the number of CSOs delivering health services independently of the state was declining. Most CSOs had shifted to advocacy work at local community and

16. Interview, February 2010.
17. Interview, October 2009.
18. Interview, Jaipur, April 2010.
19. Interview, Jaipur, October 2009.

policy level. At the time, much of the funding available to local CSOs from international funding agencies was earmarked for advocacy (a term often used synonymously with rights work) activities directed at enabling community members to demand government service provision regarding education, health and employment. This shift to advocacy work resulted in a significant change for many CSOs. While the focus in the past was largely the delivery of health services, their sole focus became awareness-raising activities. CSO workers at all levels, however, supported the shift away from health service delivery, arguing that it was ultimately the state's responsibility to provide these services. As Chetan, an indigenous-rights activist from western Rajasthan notes: 'You can get money for [health] service delivery [activities] but it's not an option for the long-term. Ultimately, it's the government's responsibility (*karna hi hai*) to provide these services. It should be our work to raise awareness (*jaagruk*) in the community about their rights to these services and to enable them to articulate these (*ki wo apni baat rakhein*)'.[20] On the other hand, some CSOs were exceptionally successful in obtaining funding and accolades from both international agencies and the Indian state, and in combining service delivery with awareness raising, training of public health workers and research activities.[21]

Returning to the issue of health service delivery, a more critical concern about the implications of rights for the functioning of the health system overall was that a focus on rights may actually obscure serious flaws in the design of health indicators and programmes. Ajit, the director of a national public health CSO based in Delhi, expressed this concern as follows:

> My concern, which is for all large programmes where medical service is concerned, [is that] there seems to be a conflation between safe and quality services with rights-based services. My question [is] — are we conflating efficient services as being equal to rights-based services and how can we segregate between efficiency indicators and rights indicators? Just to make a long list of things that are 'rights-based' is like making obeisance to the rights-based approach.[22]

Ajit's comments illustrate the current dominance of the rights-based model in development circles and how CSO actors and activists perceive and challenge this dominance.

Rights-based approaches to development were far from being uncritically accepted by CSO actors, whether at community level or operating at higher levels within their organizations. From the quotations of CSO workers above, we see that a focus on rights was viewed as inviting confrontation; supporting the marginalized, promoting individual interests; playing down duty and responsibility; enhancing institutional accountability; changing institutional

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20. Interview, Bikaner, November 2009.
21. One such organization, for example, provided pregnancy kits to local women, giving them the tools and knowledge to make decisions about their body and fertility, thereby promoting 'rights' (Unnithan and Heitmeyer, 2012).
22. Interview, Delhi, April 2010.

foci and processes; promoting collaboration with private enterprise; conflating safety with efficiency in health service delivery; and as strengthening the role of the state in service delivery. In addition, the quotations illustrate the complex interaction between 'negative' rights (civil and political rights) and 'positive rights' (economic, social and cultural rights, including the right to health).

Given the contestation among activists over what constitutes a rights-based approach, the notions of rights that are actually deployed are important to understand. As the following section illustrates, CSOs such as Endeavour work simultaneously with the state to implement rights-based initiatives through programmes such as the NRHM, and with local communities to mobilize them to demand their rights and ensure accountability from the state through protests and campaigns.

MOBILIZING FOR THE RIGHT TO HEALTH: THE CASE OF ENDEAVOUR

Endeavour is an important rights-oriented CSO in Rajasthan. It had been selected by the central government as the 'nodal' CSO to oversee community participation in health decision making at village level, a flagship intervention of rights-based health sector reform of the NRHM programme. Since its establishment in a small village in southern Rajasthan in 1979, Endeavour had undergone a series of evolutions and changes in terms of its work ethic, reflected in its expansion to setting up headquarters in Jaipur city. The main shift has been away from an autonomous, direct provision of health services to local villagers, towards advocacy work at a regional level funded by the government and international bodies (Anand, 2004). As a health activist organization, Endeavour drew explicitly on rights language in workshops, documentation, educational materials and campaign briefs, and in its description of the philosophy informing the organization's work. In 2007, the central government selected Endeavour to operationalize the NRHM vision of health rights on the ground.

In October 2009, Endeavour worked with local CSOs across the state of Rajasthan to implement the newly instituted Village Health and Sanitation Committees (VHSCs). Through these village-based committees the state seeks local participation in planning and the monitoring of funds, called 'community monitoring' (Gupta et al., 2009), to ensure that local health services respond to and match the particular needs of the communities. The VHSCs are widely advertised as promoting state accountability as well as widening participation of the community in the health sector. Endeavour worked alongside other CSO representatives and state health officials to draft the training modules and policy documents for this programme, and to draw upon their local networks to coordinate the logistic practicalities of implementing the initiative.

The CSO in Alwar was one of fourteen such local organizations across Rajasthan that worked with Endeavour. We accompanied representatives of the Alwar CSO, Indira and Manish, to a village VHSC meeting. The meeting in Alwar was held at the local primary school. Upon our arrival, a group of about fifteen villagers were sitting in a circle on the ground. These included the auxiliary nurse midwife (ANM) and the newly appointed Accredited Social Health Activist (ASHA), and three recently-elected female village council members[23] whose faces were covered with their odhani (*head wrap*) due to their embarrassment (*sharam*) in the presence of non-kin males. The remaining three-quarters of the participants present were men, including the council head (*sarpanch*) and other village leaders and representatives. The gathering itself was a remarkable achievement given continuing patriarchal norms which rarely acknowledge women as political subjects despite reservations for women for political office at the *panchayat* level. However, the gender hierarchy observed in the veiling of women did conflict with the poster distributed by the NRHM which depicted equality between men and women, sitting together, facing each other in the committee meeting.

CSOs such as Endeavour strive to realize a central assumption of programmes such as the VHSC. Central to these programmes is the belief that CSOs that have long-term experience working with these communities will facilitate better engagement with state development programmes at the grassroots level than the state. This is because the state lacks the local knowledge and sustained capacity to foster democratization within village health planning processes. As Indira explained on the way to the VHSC meeting in the village, there were significant differences between the VHSCs created by civil society groups such as Endeavour and those formed by the government: 'they [the government] sit in the office and make the committee on paper. [Instead], we have a democratic process as we consult with the community'.[24] For instance, Indira and her assistant who lived in the area provided suggestions for using money designated as 'untied funds' — money of up to Rs. 10,000 which was not 'tied' to any specific category of expenditure but could be spent on something committee members felt would benefit the village (such as having a well dug, facilitating drainage). They also helped members learn procedures to complete the auditing required by the state government, and helped facilitate discussion on the issues that were pending or had been addressed since the previous meeting.

Many activists believe that the presence of CSO workers such as Indira helps to ensure greater inclusion of marginalized groups in decision-making processes from which they might otherwise have been excluded. At its best, intervention from activists or health functionaries trusted by locals can play a

23. This is a highly significant development given the general exclusion of women in decision-making bodies at village level.
24. Interview, Rajasthan, 20 October 2009

critical role in their transcendence of hierarchies, whether of caste or gender, or both. According to Indira, government-run VHSCs faced significant challenges in creating a space for local *female* health functionaries such as the ANM and ASHA to feel sufficiently confident to assert themselves *vis-à-vis* male members of the community. She pointed out:

> The ASHA is not really empowered enough to work as a health activist — she actually needs to get the support of the community, especially its male members. In state-run VHSCs you find only women-run committees, with the ASHA, ANM and *anganwadi* worker attending. They can't get the community health projects off the ground without male support. In our VHSCs you find more male member participation and support from the community which ensures that things get done.[25]

What emerges from this and similar examples is how important a role CSOs such as Endeavour fulfil in mobilizing community engagement with rights-based programmes. There is no doubt that CSOs become powerful in their role as mediators, and equally capable of obstructing rather than facilitating the realization of rights, as is shown below. One remarkable feature of Endeavour was its effectiveness, given the range of levels at which it worked on rights issues; from village and community levels to that of policy at national level. In addition to assisting in the setting up and running of VHSCs, Endeavour also contributed to the goals of the NRHM Community Monitoring Programme by organizing public reviews (*jan sunwai*, literally 'public hearing') of local-level health services and schemes. As Govind, a village-based worker of Endeavour stated: '[As a result of our work], the community can talk directly with government officials. People can understand now that these services are for us and provided by the government. On the other hand, [government officials] also realize that these services are meant for the community and that they have an obligation to make them available'.[26]

Endeavour's rights work at local level was less explicit in its use of rights talk to mobilize local communities to demand public services from the state, while its advocacy at national and state policy level drew explicitly on human rights language. A central means through which Endeavour advocated for a rights approach to health was through its involvement in wider policy debates and planning, and particularly through campaigns promoting the right to health aimed at pressurizing the government, thus ensuring that it upheld its responsibilities as 'duty-bearer', both at national and local levels. At the national level, Endeavour was the primary representative of the state of Rajasthan in the JSA.

In its campaigning as a branch of JSA, Endeavour played a double role. First, as a civil society organization it took part in and led campaigns to put pressure on the state to uphold its responsibilities as a duty-bearer of rights. Second, Endeavour conducted a number of consultations with other

25. Interview, Rajasthan, 20 October 2009.
26. Interview, Chotti Sadri, Rajasthan, 11 December 2009.

civil society groups in Rajasthan to raise awareness around initiatives such as the National Health Bill and to gather feedback on which health matters to include in the bill (see discussion above). It had made strategic use of its role as a nodal organization in the state-run NRHM programmes to mobilize grassroots groups to hold the state accountable for its responsibilities as a duty-bearer. At the beginning of our fieldwork, we attended a workshop to launch a network of CSOs working on health in Rajasthan, the Health Equity and Rights Network. This network, set up by Endeavour, drew in organizations from more remote and less developed parts of Rajasthan, not recognized by the state authorities, and which were well enmeshed in the community. For many of these organizations, the rights-based approach captured what they did, although the language and concepts were new. The first task of the group was to translate, discuss and comment on the draft Right to Health Bill, comments which, through Endeavour, would reach the state coordinators in Delhi.

One of the more effective rights-based campaigns undertaken by Endeavour drawing on its local and national networks has been its campaign to promote the use, prescription and availability of generic medicines (rather than the costlier brand-name pharmaceuticals). Drawing on both its local Rajasthani networks with other CSOs, and its links within national movements such as the JSA, Endeavour mobilized support to pressurize the government to provide universal and quality healthcare as a basic human right. The campaign explicitly drew upon rights language to criticize state negligence in providing safe and affordable medicines. The head of Endeavour, Naresh, oversaw research into discrepancies between the production cost of medicines, people's out of pocket expenditure on the drugs and public spending, so as to illustrate gross inconsistencies and inequalities (Gupta, 2010). The Indian government was shown to spend only Rs 503 (about US$ 11.50) per capita on healthcare compared to the US$ 3,782 spent by the United States government. The various consultation meetings with other Rajasthan-based CSOs culminated in a series of public rallies organized by Endeavour and the JSA in front of the secretariat in Jaipur to protest against the lack of action on the part of the government in providing access to free medicine in the state.

Since we concluded our fieldwork, Endeavour has achieved success with its campaign with the promulgation of state legislation which enshrines the right to universal access to free generic medicines in Rajasthan (Act of October 2011). As a result, an amount of Rs 2 billion (about US$ 40 million) has been allocated to provide 352 drugs at 13,874 distribution centres in government hospitals (Srinivasan, 2011). This success has, at the national level, been attributed to the tireless efforts of Naresh, Endeavour and its networks. However, toward the end of our fieldwork in 2010, Endeavour had its state funding for local work on the VHSC programme withdrawn, pointing to the vagaries of working with the government on rights-based issues.

CONCLUDING DISCUSSION: PLURALIZING THE RIGHTS DISCOURSE IN DEVELOPMENT

Rights-based approaches have become prevalent in development rhetoric and programmes in countries such as India, yet little is known about their impact on development practice on the ground. Through an analysis of the process through which human rights are translated into specific interventions and operationalized in specific institutional contexts, this article provides insight into 'rights work' and the extent to which rights 'work' in development. The rights-based work of civil society organizations and networks such as Endeavour suggests a plurality in the discourse employed across and within organizations, as well as divergent practices and outcomes. This diversity points to the different development modalities CSO workers employ: they 'do' development in ways that carry credence and resonate with local communities, but also in accordance with state health agendas.[27] It marks a decisive shift in the way state and civil society actors interact and, in many cases, how their roles overlap[28] in their work on rights.[29]

The lack of a monolithic discourse on human rights is reflected in the variety of ways in which CSO workers in Rajasthan construe and construct the divide between rhetoric and practice: while some may view rights-based approaches as yet another development buzzword or trope, others see in it the potential for bringing about tangible social change. The different appropriations and translations of rights taking place on the ground lead us to extend Merry's analysis on the 'vernacularization' of rights to show that there is no single translation of human rights but multiple, contested and often radically re-constituted translations. This plurality of translations is reflected in the continuous discussion among CSO workers over whether human rights should be viewed positively as 'struggle' against injustice, or more negatively, as a discourse which de-emphasizes personal responsibility.

The important insights that emerged from this analysis of the multiple translations of rights are as follows: firstly, the deliberations on rights by CSO workers, especially at the national and state levels, have helped reframe the structures and processes through which state officials and health professionals (including those working with international organizations) are

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27. As the ethnographic material from Rajasthan illustrates, human rights functions as an 'empty signifier' in Laclau's (1996) sense of the term, where it becomes a nodal point, a privileged element that gathers up a range of elements and binds them together in a discursive formation.
28. The collaboration of state officials with CSOs was reported to us not merely with respect to programmes instituted through the NRHM, but more widely around programmes directly addressing the marginality and disempowerment of the poor (e.g. the rural employment guarantee scheme, NREGS, the Below Poverty Line scheme, BPL, the right to food and, most recently, the focus on health).
29. A trend already evident in Rajasthan in the late 1980s; see Mathur (2004); Unnithan and Srivastava (1997). Also see Unnithan and Heitmeyer (2012) for the way in which such collaborations support 'state activism'.

held accountable or in the 'spotlight'.[30] Secondly, at the national level, we have also seen how CSO actors use 'rights' instrumentally in the construction of policy. This was illustrated by the debate within the JSA network on whether the implementation of a universal healthcare policy could work in ways which exclude the vulnerable and marginalized. The rights work of CSOs such as Endeavour, distinctive in that it occurs across the development spectrum, within policy circles as well as with village communities, has been most effective in redressing structural inequalities concerning health, mainly at the level of national policy and planning. This was evidenced by the passing of new legislation on the basis of the campaign with the JSA network to assure universal access to free generic medicine in state hospitals. Co-opted at this level, human right language becomes a means of putting pressure on the state to implement initiatives aimed at democratizing and decentralizing access to state resources.

Thirdly, at the level of community-based health programmes, rights translation work, as illustrated by the Village Health and Sanitation Committee in Alwar, has instilled new meaning into processes of 'participation' for local actors. Engagement of local respondents has undergone a shift from merely informing communities about schemes (often taken to connote participation), to actually being involved in programmes. This means they actively participate in the planning of programmes to address their health needs and in the 'monitoring' of village-level government functionaries such as the accredited health worker and auxiliary nurse midwife. In their analysis of the reasons which compelled international development agencies to adopt rights-based approaches in the mid-1990s, Cornwall and Nyamu-Musembi (2004) suggest that rights talk provided the basis for a re-framing of the notion of community participation in development. The turn to rights signalled a shift away from the broad-based, instrumentalist participation (simply being present when plans were inaugurated, for example) characteristic of earlier programmes, toward the involvement of beneficiaries in decision-making processes about their own development (ibid.: 1424). However, as this indicates, the ways in which participation is re-framed also critically depends on development actors' understanding of rights and their sense of responsibility, morality and agency.

Fourthly, embedded within local traditions of activism and social movements, Rajasthani activists simultaneously work with indigenous notions of rights (*adhikar*, *haq*) and ideas of duty (*dharma*, *farz*). Such traditions may indeed reinforce particular normative and gender relations (for example, the emphasis legal advocates placed on the obligations of women towards their families rather than on what the state and their families owe them). However, they likewise respond to local exigencies and needs in a way that the language of human rights, with its emphasis on the individual's relationship

30. As suggested in our interview with Sita, Head of Unicef in Rajasthan, Jaipur, October 2009.

with the state over and above relations within the family and community, leave unacknowledged and unmet. As we saw, feminist-oriented activists in Rajasthan, for example, mobilize a gender perspective to re-situate notions of entitlement so that they become meaningful for local women, to think of their own needs rather than their duties in helping others (family members).

Finally, CSO worker perspectives which were explicitly critical of, or consciously avoided, rights-based approaches were equally salient in shaping activist responses to development programmes, and in turn, their impact on the communities they worked with. Organizations that rejected rights-based approaches were those whose members regarded a rights discourse as complicit in 'fixing' women and the poor as victims of development and lacking agency (as expressed in the views of Nandini). Another prevalent critique of rights among CSO members was that it generated expectations (of the state) with no attendant sense of responsibility (a view echoed by lawyers as well as the chairperson of the state Human Rights Commission). Rights talk was also viewed negatively by some CSO workers as an opportunistic device to gain development funding (as in the words of Seema of Endeavour), rendering rights-based work hypocritical.

While we acknowledge that their agendas are never purely altruistic and the translations never 'neutral', since CSO workers do not operate in a social and political vacuum, it is clear from the ethnography that these activists are doing more than simply 'ventriloquizing'[31] a human rights language for the sake of international agencies and state funders. CSO actors who position themselves at the heart of rights work also face moral dilemmas, brought home to us most lucidly by the lack of choice they faced; by being forced to give up their long-standing contributions to health service delivery in favour of rights advocacy work. In this context, CSO workers could be seen as 'seizing the moment'. As Joshi (2009: 627), in her analysis of the right to employment in the state of Maharashtra, suggests, 'having a right enshrined in law provides an incentive for activists to invest in mobilising the poor to access their rights'.

The diverse CSO worker translations of human rights, especially those informed by their proximity to the communities in question, are critical to challenging an international and state monopoly over rights frameworks, and the rhetorical use of these frameworks in structuring policy. What is noteworthy about the plurality of CSO interpretations of rights is that in the context of development programmes, rights can be used to symbolize and support conflicting development strategies. Rights can signify the struggle against the state for better healthcare and, at the same time, be a means to strengthen the role of the state in health delivery. It can be deployed to support the marginalized collectively while at the same time used to promote individual interests. It can also serve to enhance accountability of

31. This point is also made by Yarrow (2008) in his research on the conflicted subjectivities of NGO workers in Ghana.

public institutions while promoting collaboration with private enterprise. Taken together, we find that the use of an explicit rights framework is most pronounced at the higher programme and policy levels of CSO functioning and becomes more implicit (and less referred to in terms of universal rights) in community-based work.

Given the long history of engagement with rights work in a pre-'rights-based' era, CSO workers in Rajasthan who are interconnected with networks of activists nationally have developed a critical collective consciousness around rights which cannot be dismissed as promoting the interests of the economic and political elite alone. The perspective discussed in this article contributes to other social science and especially anthropological research on rights which demonstrates that the use of rights in local contexts has mainly supported existing power relations.[32] While there is no doubt that there is a predominance of middle-class and English-language professionals especially in the upper ranks of civil society organizations involved in rights work, the appropriation of the meaning and deployment of human rights is not necessarily monopolized by them as development actors increasingly come from a diverse spectrum of class, regional, religious, caste and gender backgrounds. Accordingly, the understanding of what rights mean, and how and to what effect they can be 'translated', also varies. As this article shows, such translation work has most traction and moral force when it responds to local exigencies and needs in ways that the universal language of human rights and state development discourse do not acknowledge.

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32. See Englund (2006) and Wilson (2001) as cited in the Introduction.

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